BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOSE ALVAREZ, M.D.** Holder of License No. **21702** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-04-0279A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 8, 2005. Jose Alvarez, M.D., ("Respondent") appeared before the Board with legal counsel Jay Fradkin for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact, conclusions of law and order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 21702 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-04-0279A after receiving notification of a medical malpractice settlement involving Respondent's care and treatment of a 31 year-old female patient ("AW"), specifically, an unnecessary bilateral salpingo-oophorectomy.

4. AW presented to Respondent on December 10, 1999 and gave a history of irregular vaginal bleeding, menometrorrhagia, low back pain, severe dysmenorrhea, dyspareunia, and a right ovarian cyst. AW also had symptoms of occasional bedwetting and occasional incontinence. Respondent explained the risks and complications of AW's

medical choices and AW decided to proceed with a hysterectomy, specifically, a laparoscopically assisted vaginal hysterectomy.

5. On January 20, 1999 AW presented for the surgery and Respondent performed the procedure with bilateral salpingo-oophorectomy and colpopexy with shortening of the uterosacral ligaments. Respondent's operative note indicates there was no evidence of relaxation of the anterior wall or posterior wall of the vagina. Respondent decided to do a simple hysterectomy through a laparoscope and suspension of the vaginal cuff. Respondent's operative description indicates the "cul-de-sac, bladder region, tubes and ovaries looked unremarkable." AW's postoperative course was uneventful and she was started on hormonal therapy post-operatively. AW later had symptoms of stress incontinence.

6. At the formal interview Respondent testified AW had already been scheduled for a hysterectomy by another physician, but came to him to have it performed laparoscopically. Respondent testified he performed the surgery without complication and saw AW three times after the surgery and she had no problems. Respondent noted that when AW moved to another town and saw a new physician the issues in the malpractice case arose. Respondent testified the issues arise solely from a missed dictation, specifically, because he dictated on the operative report the ovaries were unremarkable. Respondent stated the dictation was done six weeks after the actual surgery because there was no dictation in the hospital where the surgery was performed (the hospital was closing and had no dictation system.) Respondent testified he did not have the chart when he dictated the report.

7. Respondent testified he did not recall how everything looked in AW, but he has been practicing for the last thirteen years in obstetrics and gynecology and is board

certified. According to Respondent, he would not have had any reason to remove healthy ovaries.

8. Respondent was asked to explain what AW's chief complaints were. Respondent testified AW complained of mood swings, chronic pelvic pain, pain during intercourse, and recurring ovarian cysts. Respondent was asked how the pathology he noted at the time of surgery relates to the chief complaints. Respondent testified he did not recall the surgery itself, but all the signs and symptoms probably are based on a diagnosis of endometriosis. Respondent clarified that his presumptive diagnosis based upon his surgical findings was endometriosis. Respondent was asked how the endometriosis correlated with dyspareunia. Respondent testified usually when a patient has endometriosis, that is one of the most common symptoms of dyspareunia and due to the scar tissue, endometriosis implanted in the uterus and in the area, frozen pelvic.

9. Respondent was asked if he noticed a lot of scar tissue in AW's pelvis and near the ovaries when he did the surgery. Respondent testified that the surgery was in 1999 and he did not recall at this time and he has only the operative report in which he did not describe the ovaries right. Respondent was asked how his handwritten note after the surgery described his surgical findings. Respondent testified the note described the surgical findings as "necrotic pelvic pain, uterine prolapse, laparoscopic vaginal hysterectomy with corpalplexy." On questioning, Respondent admitted the scar tissue and the abnormal appearance of the ovaries was not mentioned in the note. Respondent testified he believed he did not write this note at the time of surgery and wrote it sometime thereafter. Respondent was asked whether he perhaps, since the dictation system was unavailable, could have written his notes on a piece of paper at the time of surgery so there would be a record of what he did and what he found. Respondent then testified he could have written the note at the time of surgery.

10. Respondent was asked to describe the normal treatment workup for a patient with chronic pelvic pain. Respondent testified first he would look for the source of the pain and, in AW's case, she had a long history of being seen by multiple physicians and came for a second opinion. AW had been placed on medication for chronic pelvic pain. Ultrasound at the time suggested she was having bilateral ovarian cysts and AW was complaining of heavy periods. Respondent testified he agreed with the previous physician who recommended, after a long history of management, that AW have surgery. Respondent was asked if it would be customary to perform any diagnostic tests before proceeding to surgery. Respondent testified it would sometimes be, depending on the age of the patient, whether she wants to have more children. If so, Respondent would do a diagnostic laparoscopy, however, AW already had ultrasounds.

11. Respondent was asked if he knew, before proceeding to the operating room with AW what the ultrasound findings were. Respondent testified he did and noted ovarian cyst and bulky uterus and suggestion of fibroids. Respondent was asked to review the ultrasound report and read the description of AW's ovaries. Respondent was asked if, by the ultrasound description, one ovary appeared larger than the other. Respondent testified one ovary was suggested to have a 2.7 centimeter cyst, both ovaries were described as large, basically almost the same size. Respondent was asked if AW's ovaries were within the normal limits of the size of an ovary. Respondent testified they were.

12. Respondent was asked to refer to the pathology report from the surgery. The Board noted the report, under "gross description of the ovaries," states that both ovaries are slightly enlarged and the right shows a hemorrhagic cystic area measuring up to 1.5 centimeters. Respondent was asked what medical condition would cause the ovaries to be enlarged. Respondent testified multiple things could cause the enlarged

ovaries – endometriosis, ovulation, hemorrhagic cyst, a simple cyst, many conditions. Respondent was asked if the pathologist reported any endometriosis. Respondent testified the pathologist did not and acknowledged the gross pathology report contained no evidence of endometriosis. Respondent was asked his impression of what the left ovary looked like, relying on the pathology report because Respondent had no documentation and could not recall what it looked like. Respondent testified the way the pathologist described the ovary is essentially a normal ovary and a small cyst, clear fluid, larger cyst measuring one centimeter.

13. Respondent was asked if, when a patient has pelvic pain with dyspareunia, it was customary to take out a normal ovary. Respondent testified it was not. Respondent was asked if there was any evidence to show there was anything wrong with AW's left ovary. Respondent testified that, just by the pathology report, there was not. Respondent admitted the only way to say otherwise is his testimony that he would not remove a normal ovary. Respondent was asked to refer to the diagnosis on the pathology report that stated the left and right ovaries were benign. Respondent testified he believed the pathologist's reference to "benign" involved cancer and not in any way of any other pathological findings.

14. Respondent was asked to point out where in the body of the pathology report there was something remarkable noted under either the gross or microscopic examination of the ovaries that would tell the Board anything other than the ovaries being benign, fibrosis. Respondent testified the pathologist talked about the hemorrhagic cyst and the enlargement of both ovaries in gross inspection and he talked about the hemorrhagic inception on the right ovary and paratubal cyst. Respondent was asked about the left ovary. Respondent testified the pathologist only mentioned the small cyst and clear fluid and larger cyst measuring one centimeter on the left ovary. Respondent

was again asked if the pathologist noted anything abnormal about the left ovary. Respondent mentioned the gross inspection of enlargement, but the Board noted Respondent had earlier testified it was within normal limits. Respondent then noted the pathologist talked about the fibromuscular tissue uniform in the surface in the gross inspection of the uterus. Respondent was again asked what on the pathology report tells the Board there was something wrong with the left ovary. Respondent testified the pathology report does not explain anything being wrong with the left ovary.

15. Respondent was asked why he could not have dictated an operative report during the six week period there was no dictation available at or through the hospital where he performed the surgery. Respondent testified the system was not available for him to dictate because the hospital was closing. Respondent was asked if he had other options, such as dictating it in his office and then passing it on. Respondent testified his assistant called the hospital and was given a 1-800 number to use, but before that, there was no method in the hospital to dictate. Respondent was again asked if he had alternatives that would have allowed him to make a record of the operation, such as handwritten documentation, his own dictation service, or typing the report himself. Respondent testified that everything, including the chart, was taken out of the hospital to another location. Respondent was asked if the records were removed the day of surgery. Respondent testified they were not, but the first time he saw the chart again was when the litigation began.

16. Respondent was asked if based on the pre-operative admission orders that say "LAVH, BSO" it was his thought process prior to going to the operating room that he might consider a bilateral salpingo oophorectomy. Respondent testified it was and that is why the consent form said "proceed according to findings." Respondent was asked if LAVH and BSO were serious considerations prior to going to the operating room why the

consent did not specifically state LAVH, BSO. Respondent testified he did not want to remove healthy ovaries so he gave the option to see if the ovaries were safe and he assumed that was the reason he did not put LAVH, BSO – in order for him to proceed according to his findings in surgery. The Board noted it did not see in Respondent's preoperative counseling with AW about informed consent any discussion of possible LAVH, BSO. Respondent was asked to show the Board where in the records that discussion is because it is clear based upon the pre-authorization that it was something he was considering, but it is also clear based on AW's complaint that she was surprised by what Respondent did. Respondent testified AW was properly informed several times in his notes of the LAVH, BSO and AW already came from a second opinion where she was already scheduled for a TAH, BS – TAH and possible left salpingo oophorectomy or cystectomy and she knew in advance the chances of taking needle hormones after that or not.

17. Respondent was asked if there is a difference between a hemorrhagic and nonhemorragic cyst in the ovaries. Respondent testified sometimes a simple cyst could be just an ovulation cyst, a simple benign cyst and a hemorraghic cyst could be a copulating cyst that started to bleed or, in a case like AW's, could be endometrioma or some other condition like that. Respondent was asked if there was a difference in whether one or both ovaries were removed in terms of the patient's outcome or need for hormonal replacement. Respondent testified that sometimes removing one ovary causes the symptoms to get worse in way of lack of estrogenic effect. Respondent noted that depending on the age of the patient, you try to preserve the ovaries as much as possible. Respondent was asked if an attempt should be made to preserve the ovaries in a 31 year-old patient, such as AW. Respondent testified he assumed the reason he removed the ovaries was because he saw endometriosis and the standard of care with a patient

with chronic pelvic pain is hysterectomy and removal of the ovaries. The Board noted that it had already established the pathology report shows no evidence of problems with the left ovary and Respondent's operative report does not have any pathology on the left ovary.

18. Respondent was asked how many major cases a week he did on average in 1999. Respondent testified he averaged probably two or three major cases a week. Respondent was asked how he remembered what he did in each of these procedures for a period of six weeks until he finally dictated the report. Respondent testified he did procedures in hospitals other than the one where he did AW's surgery that did not have the dictation system. Respondent was asked how he even remembered exactly what was done in AW's case six weeks later. Respondent testified this was the reason dictation should be done right away after surgery. Respondent testified he had no hand-written notes because he did not have the chart available either. Respondent was asked if he agreed that without handwritten notes or some other written recollection his dictation six weeks later was worthless from a medical point of view. Respondent agreed. Respondent was asked if his current consent form was more detailed. Respondent testified he had improved a lot of things since 1999.

19. The Board's medical consultant noted the only anatomic abnormality reported on the surgery specimens was the hemorraghic cyst of the right ovary and the pathologist submitted that endometriosis may have something to do with that, but there was no evidence of that disease otherwise and the Board's obstetrics and gynecology consultant opined the most common reason for a hemorraghic cyst to the ovary is normal ovulation. The medical consultant was asked if there was any addendum to the pathologist's report based on his re-review of the slides for the malpractice litigation. The medical consultant noted there was not.

20. The standard of care required Respondent to preserve AW's ovarian function and not remove a healthy ovary.

21. Respondent fell below the standard of care because he did not preserve AW's ovarian function and removed a healthy ovary.

22. AW was subject to potential harm because of the possible consequences of hormonal replacement therapy she was required to undergo after the ovary was removed.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Letter of Reprimand for removing a healthy ovary during a laparoscopic hysterectomy.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a

rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 13th day of October, 2005.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 13th day of October, 2005 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 13th day of October, 2005, to:

Jay Fradkin
Jennings Strouss & Salmon PLC
201 East Washington – 11th Floor
Phoenix, Arizona 85004-2385

Executed copy of the foregoing mailed by U.S. Mail this 13th day of October, 2005, to:

Jose Alvarez, M.D.
Address of Record

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